|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **South Carolina Workers’ Compensation Commission**1333 Main Street, Suite 500 ● Post Office Box 1715Columbia, South Carolina 29202-1715(803) 737-5700 [www.wcc.sc.gov](http://www.wcc.sc.gov) | SCSealBWjpg |

|  |  |
| --- | --- |
| WCC File #: |  |
| Carrier File #: |  |
| Carrier Code #: |  |
| Employer FEIN #: |  |

 |
|

|  |  |  |  |
| --- | --- | --- | --- |
| Claimant's Name: |       | SSN: |    -  -     |
|  |  |
| Address: |       |
|  |  |  |  |  |  |
| City: |       | State: |    | Zip: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Home Phone: | (     )    -     | Work Phone: | (     )    -     |
| Date of Injury: |       |  |  |

 |

|  |  |
| --- | --- |
| Employer's Name: |       |
|  |  |
| Address: |       |
|  |  |  |  |  |  |
| City: |       | State: |    | Zip: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Insurance Carrier: |       |  |  |

  |
|  Preparer’s Name: |       |  Law Firm: |       |  Preparer’s Phone #:  | (     )    -     |
|  |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Injury or Illness:** |  |  | **Estimated time for hearing:** |

**Complete each information blank. Clearly specify when contentions are admitted in part and denied in part. The Employer/Carrier in answer to the claim, respectfully shows:**

1. It is  the employee sustained an injury or illness on or about the date set forth in the Form 50. The reasons for denial are:

|  |
| --- |
|       |

1. It is  both the employer and employee were subject to the Workers’ Compensation Act at the time in question. The reasons for denial are:

|  |
| --- |
|       |

1. It is  the relationship of employer and employee existed at the time in question. The reasons for denial are:

|  |
| --- |
|       |

1. It is at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are:

|  |
| --- |
|       |

1. It is notice of injury was given the employer.  The reasons for denial are:

|  |
| --- |
|       |

1. It is the employee  medical care as a result of injury or illness. The reasons for denial are:

|  |
| --- |
|       |

1. It is the employee is entitled to temporary total disability for the period(s) of :

|  |
| --- |
|       |

1. It is  the employee is permanently disabled. The reasons for denial are:

|  |
| --- |
|       |

1. It is the employee has serious disfigurement.
2. It is contended that an average weekly wage of **$**  applies, according to attached Form 20 as provided by law.
3. Further contentions, grounds of defense, or unusual aspects are:

|  |
| --- |
|       |
|       |

 [ ] **Mediation**

[ ] a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.

[ ] b. Mediation is required pursuant to Reg. 67-1802.

[ ] c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.

[ ] d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to **mediation@wcc.sc.gov**.

**I certify I have served this document pursuant to Reg. 67-211. See attached certificate of service.**

**I verify the contents of this form are accurate and true to the best of my knowledge.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| Preparer’s Signature |  | Title |  | Email |  | Date |

|  |  |  |  |
| --- | --- | --- | --- |
| Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Refer to R. 67-1801 for mediation. Questions about the use of this form may be directed to the Commission’s Judicial Department at 803-737-5675 or **judicial@wcc.sc.gov** or **mediation@wcc.sc.gov**. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

|  |  |  |
| --- | --- | --- |
| **WCC Form # 51**Revised 09/23 | 51 |  Employer’s Answer to Request for Hearing |

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